



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 25, 2012

Ms. Patricia Horn, Administrator
Cedar Hill Health Care Center
49 Cedar Hill Drive
Windsor, VT 05089

Provider #: 475046

Dear Ms. Horn:

Enclosed is a copy of your acceptable plans of correction for the re-certification survey conducted on **June 27, 2012**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in cursive script, reading "Pamela M. Cota".

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure - **This version replaces the former Accepted POC (survey dated 6/27/12) with cover letter dated August 1, 2012.**



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED
Division of
SEP 18 12

PRINTED: 09/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		Licensing and Protection	(X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000				
F 157	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's</p>	F 157	<p>All behaviors occurring more than 2 days consecutively or occurring more than 3 times in a 7 day period will have MD notified via fax form. MD will be responsible to respond to fax with verification of his receiving it and acknowledgment of behaviors. MD may use this fax to initiate new orders or interventions. All initial faxes will be kept in the Fax log book until MD has returned signed fax. The signed fax will be filed in the back of the MD progress note section. If a new order is on form, a copy will be placed in the Physician order section of chart and taken off as a normal order.</p>			8/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Fabricia Alm *LNHA* *9/19/2012*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the primary physician of an increase in combative behaviors and agitation for 1 resident of 31 (Resident #35) in the Stage 2 sample. The findings include: 1. Per review of the medical record, Resident #35 was admitted to the facility on 12/4/11 with diagnoses that include dementia with behaviors. Per the psychological evaluation dated 4/13/12, the evaluation indicates that Resident #35 has a history of dementia and was seen for evaluation of the dementia and behavior problems. The evaluation indicates that Resident #35 has a history of striking out with care. Per review of the nurse's notes, Resident #35 was medicated with an as needed (PRN) dose of Ativan for combative behaviors and agitation on 5/11, 5/12, 5/23, 5/24, 5/25, 5/26, 5/27, 5/28 and 5/31. Per review of the nurse's notes, the notes indicate that Resident #35 has sustained bruising as a result of his/her combative behavior. Per review of the comprehensive care plan titled "At risk for untoward effects of Haldol, Psychotropic drug use" initiated on 12/11/11, the care plan indicates that "if resident presents with increased combative behaviors then report to physician". Per review of the physician notes, there was no documentation that the physician was notified of any increase in combative behaviors from 5/2/12 until 6/10/12 when the physician was notified via fax. Per review of the facility's policy	F 157	DNS/designee will monitor Behavior sheets and PRN to ensure that MD has been notified as outlined above at least 2 times a week. DNS/designee will audit the MD fax book to ensure that MD has responded to faxes on a weekly basis. All nurses will be educated on the new Behavior Fax form and its process. <i>F157 PR accepted 9/6/12 pmedical</i>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page 2 titled "Problematic Behavior Management", the policy indicates "the staff will identify, document and inform the physician about an individual's mental status, behavior, and cognition." Per interview with the DNS on 6/27/12 at 1:09 PM, he/she confirmed that no physician had been informed from 5/2/12 to 6/10/12 of Resident #35's increase in behaviors, and the DNS confirmed that the resident should have been re-assessed for the increase in behaviors.	F 157			
F 280	483.20(d)(3); 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	Resident #15 Skin Integrity risk care plan was immediately updated to reflect history of reddened heels as well as failed attempts by resident refusal to float/elevate heels and to use booties as prevention.		
	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the</p>		<p>1. The DNS <u>did not confirm</u> that the red heels were not getting better on Resident #15 and that they remained the same since 4/20.</p> <p>2. The bilateral red heels had not remained the same since 4/20 and in fact had resolved.</p> <p>3. The surveyor, the DNS and RN responsible for wounds went to visually inspect the bilateral heels and noted that the areas were healed and no longer red or pink.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	<p>Continued From page 3</p> <p>facility failed to revise the comprehensive care plan for 1 resident of 31 in the Stage 2 sample (Resident #15) to reflect the resident's current medical status with goals and interventions specific to meet the resident's current needs. The findings include:</p> <p>1. Per review of the medical record on 6/27/12, Resident #15 was re-admitted to the facility on 4/18/12 with diagnoses that include dementia and syncope. Per the nurses notes dated 4/20/12, the notes indicate that Resident #15 has reddened heels, and a new order was obtained for skin prep to heels three times a day. Per the nurses notes on 5/4, 5/11, 6/8 and 6/21, Resident #15 has bilateral reddened or pink heels and skin prep was applied. Per review of the nurses notes, there was no evidence that any other interventions were utilized to help resolve the bilateral reddened heels and no interventions to prevent reoccurrence. Per review of the comprehensive care plan initiated on 4/30/12 titled "At risk for skin integrity impaired", there was no documentation identifying the reddened and pink heels identified on 4/20/12, and there was no documentation to indicate any specific interventions to help resolve the bilateral reddened heels and prevent reoccurrence.</p> <p>Per interview with the Director Of Nursing (DNS) on 6/27/12, he/she confirmed that Resident #15 had been identified on 4/20/12 to have bilateral reddened heels. The DNS indicated that the redness indicates potential area for skin breakdown and pressure sores to develop. The DNS confirmed that the bilateral red heels were not getting better and that the area is remaining the same since identified on 4/20/12. The DNS</p>	F 280	<p>ADNS/designee will audit care plans on a weekly basis to update and audit for appropriate interventions that reflect the current POC effective June 28, 2012. Nurses will be educated on proper procedure for updating care plans and will take part in the over site and revision of care plans to ensure that any new order is followed up with care plan update. Interdisciplinary team will review each care plan individually after each assessment to ensure that all areas are covered. Nurses and primary LNAs will be consulted before team meetings.</p> <p><i>F880 POC accepted 9/12/12 pme/apn</i></p>		8/1/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 4 indicated that the nurses were utilizing skin prep three times a day. The DNS indicated that the staff had attempted to float the resident's heels but he/she was noncompliant. The DNS indicated that Resident #15 wears shoes or slippers and at times will allow staff to put him/her in a recliner to put heels up. Per review of the comprehensive care plan with the DNS on 6/27/12, he/she indicated that the care plan dated 4/30/12 did not address the bilateral reddened heels identified on 4/20/12, and did not address any resident specific interventions to treat the current area and prevent reoccurrence of the area.	F 280			
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide services for 1 resident of 31 (Resident #35) in the Stage 2 sample. The findings include: 1. Per review of the medical record, Resident #35 was admitted to the facility on 12/4/11 with diagnoses that include dementia with behaviors. Per the psychological evaluation dated 4/13/12, the evaluation indicates that Resident #35 has a history of dementia and was seen for evaluation of the dementia and behavior problems. The	F 282	All behaviors occurring more than 2 days consecutively or occurring more than 3 times in a 7 day period will have MD notified via fax form. MD will be responsible to respond to fax with verification of his receiving it and acknowledgment of behaviors. MD may use this fax to initiate new orders or interventions. All initial faxes will be kept in the Fax log book until MD has returned signed fax. The signed fax will be filed in the back of the MD progress note section. If a new order is on form, a copy will be placed in the Physician order section of chart and taken off as a normal order.	8/1/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5 evaluation indicates that Resident #35 has a history of striking out with care. Per review of the nurse's notes, Resident #35 was medicated with an as needed (PRN) dose of Ativan for combative behaviors and agitation on 5/2, 5/4, 5/10, 5/12, 5/23, 5/27, 5/28, 5/31, 6/5, 6/7, 6/8, 6/9 and 6/10/12. Per review of the nurse's notes, the notes indicate that Resident #35 has sustained bruising as a result of his/her combative behavior. Per review of the comprehensive care plan titled "At risk for untoward effects of Haldol, Psychotropic drug use" initiated on 12/11/11, the care plan indicates that "if resident presents with increased combative behaviors then report to physician". Per review of the physician notes, there was no documentation that the physician was notified of any increase in combative behaviors until 6/10/12 via fax. Per review of the facility's policy titled "Problematic Behavior Management", the policy indicates "the staff will identify, document and inform the physician about an individual's mental status, behavior, and cognition." Per review of the behavior monthly flow record for May and June, with the Director Of Nursing (DNS) on 6/27/12, he/she indicated that the interventions listed on the flow record were tried and were unsuccessful prior to the administration of Ativan. The flow record indicates and the DNS confirmed that 11 interventions (redirect, 1:1, ambulation, activities, return to room, tilting, giving food, giving fluid, changing resident's position, encourage rest, and a back rub) were tried and were unsuccessful, causing the nurses on 5/11, 5/12, 5/23, 5/24, 5/25, 5/26, 5/27, 5/28 and 5/31 to administer as needed Ativan for agitation and combative	F 282	DNS/designee will monitor Behavior sheets and PRN to ensure that MD has been notified as outlined above at least 2 times a week. DNS/designee will audit the MD fax book to ensure that MD has responded to faxes on a weekly basis.	
			All nurses will be educated on the new Behavior Fax form and its process. <i>F282 POC accepted 9/24/12 Pmcstarn</i>	

PRINTED: 09/04/2012
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page 7 regimen of 1 resident of 4 reviewed in the stage 2 sample (Resident #25) remained free from unnecessary drugs by administering a higher dose of medication than what was ordered by the physician on 5 occasions during May 2012. Findings include: 1. Per record review on 6/27/12 at 10:00 A.M. Resident #25's medical record contains a Physician's Order dated 4/20/12 decreasing the dose of Ativan (an anti-anxiety psychotropic drug) from 0.5 milligrams (mg) to 0.25 mg by mouth up to four times a day PRN (as needed). Nursing Notes for that day record the decrease in dosage and that Resident #25's daughter was called and approved the new orders. Per record review, Resident #25 has a Care Plan which includes a "risk for untoward effects of psychotropic drug use: Ativan used to treat anxiety". Approaches for the plan of care include "medications per orders". A Care Plan Action Notice on 4/30/12 lists "Nursing: reviewed changes in medication. Ativan decreased". Per record review, Resident #25's Medication Administration Record (MAR) for May, 2012 documents a dose of 0.5 mg of Ativan given on 5/4, 5/6, 5/10, 5/26, & 5/29/12. Per interview on 6/26/12 at 2:09 P.M., the facility's Director of Nursing Services confirmed that the Physician's Order decreasing Resident #25's dosage of Ativan on 4/20/12 was not transcribed to the MAR, and that Resident #25 was administered a dose of Ativan larger than the ordered dose on 5 different occasions in May 2012.	F 329	<p>4. One designated Nurse will be assigned second and final checks on MARS prior to the start of each month.</p> <p>5. It is the expectation of Cedar Hill that the Nurses who work the first day of the month to take old MAR with new MAR and compare both MARS during that pass for a third check to ensure that MARS are accurate from month to month.</p> <p>MAR process and identified problems will be reviewed at least quarterly with the Quality Assurance Committee.</p> <p><i>F329 PDC accepted 9/24/12 Pmeotari</i></p>		6/28/12
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 334	Continued From page 8 The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 334	Policy and Procedure for Influenza Immunizations was revised to include the dates of the flu season as defined by Federal regulation (October 1 through March 31), and to include that each resident, and/or resident representative will be given proper education regarding influenza vaccination for that year as set forth by CDC. Annual consent for immunization will be obtained.	7/16/12	
	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;		Influenza Informed Consent forms will be revised to include a section to document that education regarding the vaccination was given to the resident or representative at time of requesting consent. This information will be kept in the resident's record. The Infection Control Nurse or designee will check to make sure that all consents are obtained before administration of vaccine.	7/16/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 334	Continued From page 9 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide documentation of consent received for vaccine administration and/or education provided regarding the benefits and risks of influenza immunization, for 4 of 5 residents or their legal representatives in the applicable stage 2 sample (Residents #7, #11, #13, #30), each time the vaccine is offered. Findings include: 1. Per record review, the facility failed to develop	F 334	Quality Assurance Committee reviews flu vaccination policy and procedures, and vaccinations pending and completed yearly during the flu season. <i>F334 POC accepted 9/12/12 Pmevian</i>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 334	Continued From page 10 1. Per record review, the facility failed to develop and implement a policy and procedure that assures that each resident or their legal representative has the opportunity to accept or refuse vaccination, and receives education regarding the benefits and side effects of the influenza vaccine each time it is offered. The facility's written procedure states that "Residents who received vaccine in previous years and who have signed or whose responsible party has signed will not have to renew permission". The written policy and procedure does not address education regarding benefits and side effects of the vaccine. The facility provided information which indicated that 8 residents received influenza vaccine during the 2011-12 influenza season. During record reviews, there was no evidence in the medical records of 4 of 5 residents in the stage 2 sample (Residents # 7, #11, #13, and #30) that they or their responsible party had either given consent for immunization or received education regarding the benefits and side effects prior to being administered the vaccine on 10/7/11. During an interview with the Assistant Director of Nursing (infection control nurse) on 6/27/12 at 10:45 AM, s/he confirmed that the facility could not provide evidence of consent by the residents or their responsible parties, or education provided regarding benefits and side effects of the influenza vaccine prior to administration each time the vaccine was offered.	F 334			